AMERICA'S PHYSICIAN GROUPS

May 20, 2024

The Honorable Jonathan Kanter
Assistant Attorney General
Antitrust Division
Department of Justice
450 5th St NW
Washington, DC 20530

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

The Honorable Lina M. Khan
Chair
Federal Trade Commission
600 Pennsylvania Ave NW
Washington, DC 20580

Docket No. ATR 102: Request for Information on Consolidation in Health Care Markets

Dear Mr. Kante, Mr. Becerra, and Ms. Khan:

Thank you for the opportunity to respond to this request for information at a critical time in the evolution of the nation's health care system. APG welcomes your agencies' openness to stakeholder input and your ongoing commitment to assuring that the health care ecosystem delivers high-quality, equitable, cost-effective, and person-centered health care to all citizens and residents of our nation.

Below, APG will first provide (I) a brief description of our organization, followed by (II) our view of relevant developments in health care consolidation, and (III) our recommendations to your agencies as they continue their work. Together these contributions reflect the voice of APG's membership and our commitment to working with your agencies as you contemplate policy changes that will enhance, rather than impede, the necessary evolution of U.S. health care.

In summary, our recommendations are as follows:

(1) There are many reasons to stay alert to excessive market consolidation in health care, such as "rollups" of specialty physician practices that may be designed to exploit higher fee-for-service payments for certain health care services and can be anti-competitive in their operations or intent. These arrangements can contradict the spirit of value-based health care, and do not align with APG member groups' focus on being held accountable for the costs and quality of health care, including through specialty-focused alternative payment models.

(2) Transparency about consolidation trends is important, and APG notes that many states have already enacted legislation requiring pre-closing notification of material changes in ownership of health care entities. A federal reporting requirement may also be appropriate to allow broader monitoring and understanding of consolidation, provided that the federal requirement would be limited to retrospective reporting of material changes in ownership that took place in the prior year; assigned responsibility for reporting to the new owner; and set reasonable boundaries on the size of transactions that must be reported (e.g., more than $100 million in annual revenue).

(3) Notwithstanding some deleterious aspects of consolidation, there are far more fundamental drivers of ownership changes in health care than what has been characterized as "corporate greed." The agencies should take these factors into account as they contemplate the potential for any policy action. There is an economy-wide trend toward greater ownership concentration and larger firm sizes from which health care is not immune. In addition, factors unique to health care consolidation include a decline in the number of community hospitals; the evolution of health insurance; public payment pressures; the lack of ability of independent and relatively smaller physician practices and medical groups to survive in the marketplace, given legal and regulatory realities, practice costs, and the need to invest in and maintain a costly health information technology infrastructure; and the aging and retirement of much of the health care workforce, including physicians.

(4) In analyzing the effects of consolidation, and considering any future policy changes, the agencies should (a) consider first and foremost the appropriate policy goals of health care system transformation and the implications for both care delivery and payment, particularly in moving to more value-based health care; (b) develop a more nuanced understanding, and a better capacity to measure and evaluate the outcomes of, private investment and consolidation trends that drive toward this fundamental goal of health care transformation; and (c) develop a unified federal approach to this central aspect of national health care policy that will drive in a coherent and positive direction. True "consumer welfare" in the modern health care era must comprehend a range of outcomes – price and affordability, but also quality, achievement of key patient-reported outcomes, meeting consumer preferences, assuring access to the most effective interventions, achieving the overall cost effectiveness of care, and enabling health systems to innovate in and adapt to the use of technologies such as artificial intelligence.

(5) There has been historic underinvestment in primary care, and to undertake appropriate delivery system transformation, independent physician groups need substantial capital, both to make the investments in infrastructure needed to provide advanced primary care as well as to accept the downside risk inherent in capitation or two-sided risk arrangements. The

agencies should not undertake any actions that impede attempts by the private sector to create new, sustainable models of primary care. Examples of private-equity-backed primary care entities that have been members of APG are Iora Health, which was absorbed by One Medical, itself now a division of Amazon; Oak Street Health, now a division of CVS Health; VillageMD, a division of Walgreen; and WellBe Senior Medical. The fact that several of these organizations have been absorbed by public companies, rather than undergoing initial public offerings themselves, underscores the ongoing difficulties of earning meaningful returns in primary care, but any efforts to block or slow private-equity-backed or other private-sector attempts to create sustainable models of primary care delivery will ultimately be harmful to the nation.

(6) The Request for Information notes that the agencies seek to learn more about such transactions as occur "when insurers purchase primary care practices outright." Although these organizational strategies are sometimes mischaracterized as aspects of vertical integration, they are better understood as diversification within the broad health care sector. Multiple organizations formerly thought of as "health insurers" now refer to themselves as health care or "health solutions" companies," reflecting diversification into other services – particularly involving data, information, and analytics to support the provision of health care, as well as direct care delivery through ownership of physician groups, home care entities, ambulatory surgery centers, and more. To the degree that these organizational strategies drive toward alignment of care delivery and financing, as through value-based payment models, they can help to achieve the expanded definition of "consumer welfare" described above. The agencies should develop new methodologies for measuring these broader aspects of consumer welfare across the health care system, including to understand the performance of these newer care arrangements and the results of diversification referenced above.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value-based health care, and that engage in the full spectrum of alternative payment models, including the Medicare Shared Savings Program and Medicare Advantage (MA). APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for approximately 90 million patients, including roughly 30 percent of all Medicare beneficiaries who are enrolled in the Medicare Advantage program, as well as many other millions of patients in traditional Medicare.

APG's motto, "Taking Responsibility for America's Health," underscores our physician groups' preference for being in risk-based, accountable, and responsible relationships with all payers, rather than being paid by commercial health plans or Medicare on a fee-for-service basis. Delegation of risk from payers, including the government, to providers, creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide under traditional fee-for-service payment systems. APG's member organizations participate in a full range of alternative payment models in the public and private sectors. These arrangements include the Medicare Shared Savings Program and

multiple models created by the Center for Medicare and Medicaid Innovation, ranging from primary-care-focused models such as ACO REACH to more specialty-focused models such as Kidney Care Choices.

APG's member organizations are at the epicenter of many of the ownership changes currently afoot in health care. Along with hundreds of independent primary care and multispecialty physician practices engaged in the full range of alternative payment models, our members now include Oak Street Health, which was originally a private-equity-backed organization that was purchased last year by CVS; One Medical, which earlier absorbed another of our members, private-equity backed Iora Health, and which is now owned by Amazon; and multiple formerly independent physician groups now owned by or affiliated with Optum. Because APG's membership straddles so many domains within the physician practice world, we believe that we are well positioned to offer our interpretation of the changes under way and afford your agencies with a genuine on-the-ground perspective that we hope you will use to both inform and guide policy.

II. APG's View of Consolidation in Health Care

It is well established that there are many reasons to stay alert to excessive market consolidation in health care, as President Biden noted in the 2021 executive order calling for a "whole of government" effort to promote competition.[1] Multiple studies have shown that horizontal consolidation – as when hospitals or physician groups buy comparable providers within the same market or engage in some cross-market mergers – can reduce competition and cause prices to rise without any clear benefits for patients.[2] Evidence continues to accumulate that variation in the hospital prices paid by commercial payers is attributable mainly to the power of given hospitals in specific markets.[3]

There are also legitimate reasons to raise questions about other aspects of consolidation, such as "rollups" of specialty physician practices, as evident in the FTC's lawsuit against U.S. Anesthesia Partners (USAP) and its allegedly anticompetitive attempt to consolidate anesthesiology practices in Texas.[4] APG notes that although a federal court has now dismissed the private equity firm Welsh Carson as a defendant in the case, it has allowed the FTC's claims against USAP to proceed.[5] As a matter of precedent, it will be important to determine whether USAP's actions have been primarily designed to raise anesthesia prices, which would run counter to APG's commitment to fostering primary care and specialty care integration and operating under cost-effective value-based payment models that improve health resource utilization.

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[1] https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/

[2] Dafny L, How Health Care Consolidation Is Contributing to Higher Prices and Spending, and Reforms That Could Bolster Antitrust Enforcement and Preserve and Promote Competition in Health Care Markets. Testimony to U.S. House Committee on the Judiciary Subcommittee on Antitrust, Commercial and Administrative Law, April 29, 2021.

[3] Whaley CM et al, Prices Paid to Hospitals by Private Health Plans. RAND Corp., May 13, 2024. At https://www.rand.org/pubs/research_reports/RRA1144-2.html

[4] www.ftc.gov/system/files/ftc_gov/pdf/2010031usapcomplaintpublic.pdf

[5] Memorandum Opinion and Order, Civil Action No. 4:23-CV-03560, Entered May 13, 2024, United States District Court Southern District of Texas, Houston Division Federal Trade Commission, Plaintiff, vs. U.S. Anesthesia Partners, Inc., et al, Defendants.

Notwithstanding the legitimate issues described above, APG urges the agencies to embrace a more nuanced view of health care consolidation than appears evident in the agencies' request for information, and particularly as expressed in the headline on the FTC's website citing the "Cross-Government Inquiry on Impact of Corporate Greed in Health Care."[6] With all due respect to the agencies, there are more fundamental drivers pushing consolidation in health care than "corporate greed." In the tradition of Chesterton's fence, APG believes that that any future regulatory actions can only be successful to the extent that the agencies consider and address all of these fundamental factors driving consolidation; that they also consider the degree to which any actions to thwart consolidation could impede the needed transformation in health care delivery; and that they fully take into account the potential limits of policy actions given the broader and more far-reaching forces at work in the sector and the U.S. economy.

For example, published academic research, government analyses, and the grey literature have all made the following points:

- There is "an economy-wide trend toward greater concentration toward greater ownership concentration and an increase in the dominance of large, established firms accompanied by rising markups."[7] Health care is no exception. The ten largest health systems accounted for 22 percent of nonfederal general acute care hospital beds in 2022.[8] In 2016, 90 percent of Metropolitan Statistical Areas (MSAs) "were highly concentrated for hospitals, 65 percent for specialist physicians, 39 percent for primary care physicians, and 57 percent for insurers."[9]

- Growing concentration in the health care provider and insurer markets today is "a symptom of two distinct [trends]: the decline of community hospitals and the evolution of health insurance products."[10] For more than two decades, health care has been moving gradually from inpatient settings into outpatient and home settings, while insurers have adopted narrow- and tiered-network plans that employ cost-sharing incentives to nudge patients toward lower-cost providers through copayment incentives, which are becoming increasingly prevalent.

- An additional factor driving consolidation in health care is the lack of ability of independent and relatively smaller physician practices and medical groups to survive in the marketplace, given legal and regulatory realities; practice costs, including the need to maintain a costly health information technology infrastructure; consumer expectations, and multiple other factors. As with the decline in the number of community hospitals, this trend in effect represents the fundamental shift of much of the U.S. health care sector away from its longtime de facto "cottage-industry" character to a more industrial organization approach. As a result, roughly four in five physicians (77.6%) are now employees of hospitals/health systems and other corporate entities.[11] Given the growing costs and sophisticated demands of running a medical practice, eight in 10 physicians surveyed by the American Medical Association said that the need to negotiate higher payment rates was either an important or very important reason that their

[6] https://www.ftc.gov/news-events/news/press-releases/2024/03/federal-trade-commission-department-justice-department-health-human-services-launch-cross-government
[7] https://www2.census.gov/ces/wp/2022/CES-WP-22-07.pdf
[8] https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/
[9] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0556
[10] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0555
[11] https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023 d

practice was sold to, or acquired by, a hospital or health system.[12] Other physicians are selling their practices to private equity funds, which can pay more than hospitals, given that payments by a hospital to a physician or physician group can be deemed to constitute a direct or indirect inducement for patient referrals in violation of the Anti-Kickback Statute. Still other medical groups are selling, often under financial duress, to divisions of public companies such as Optum.

A case in point was the Corvallis Clinic, a more than 100-physician multispecialty practice in Oregon that in March 2024 said it faced "lack of stability from a cash perspective"[13] even though its physician owners had cut their compensation by 15 percent. "The Oregon Health Authority declined to proceed with the required review of the clinic's sale to Optum Oregon on the ground that "There is an emergency situation…which immediately threatens health care services" and that "the transaction is urgently needed to protect the interest of consumers" because the clinic organization was insolvent.[14]

- Public policy that has been effectively driving down payments to health care providers is helping to fuel consolidation in health care. The Medicare Physician Fee Schedule has no automatic adjustment for rising practice cost inflation, and as a result, has effectively cut payments to physicians by an estimated 26 percent in real terms from 2002-2023.[15] Medicare physician fees will fall another 1.8 percent this year, in the face of a projected increase in inflation in practice costs – as measured by the so-called Medicare Economic Index, or MEI – of 3.1 percent.[16] The 2023 Medicare Trustees' report stated plainly that long-term forecasts of Medicare's financial viability are predicated on unrealistic expectations of how low payment can go while still inducing enough physicians and other providers to care for Medicare enrollees.[17] Or as the Centers for Medicare & Medicaid Services' actuaries put it: "There is a strong likelihood… that Congress would find it necessary to legislatively override or otherwise modify the [scheduled payment] reductions in the future to ensure that Medicare beneficiaries continue to have access to health care services."[18]

- An additional factor driving consolidation is the aging of much of the health care workforce, and particularly, of physicians. According to the 2022 National Sample Survey of Physicians (NSSP) conducted by the American Association of Medical Colleges, many physicians report planning to retire at ages 60, 65, and 70 (Exhibit V-4). Few physicians remain active past age 75, and many of

[12] Kane CK, Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022. American Medical Association Policy Research Perspectives, July 2023. Accessed at https://www.ama-assn.org/practice-management/private-practices/generational-trends-underlie-doctors-move-private-practice.

[13] https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/018-Optum-TheCorvallis-Clinic-HCMO-Emergency-Exemption-Application-PUBLIC.pdf

[14] https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/018-Optum-TheCorvallis-Clinic-Emergency-Exemption-Determination.pdf

[15] Medicare Physician Payment Adequacy: Budget Neutrality. The American Medical Association. https://www.ama-assn.org/system/files/medicare-basics-medicare-economic-index.pdf

[16] March 2024 Report to the Congress: Medicare Payment Policy, p. 90. The Medicare Payment Advisory Commission. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf.

[17] The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Washington, DC, March 31, 2023.

[18] Shatto J, Klemens MK, Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers. Memorandum from CMS Office of the Actuary, March 31, 2023. Accessed at www.cms.gov/files/document/illustrative-alternative-scenario-2023.pdf

these older physicians have reduced work hours per week. These realities portend a broad near-term exodus from the physician workforce commensurate with general population demographics and retirement patterns. Furthermore, it has long been the case that many independent physician practices, and particularly smaller ones, have generally retained no earnings and have no reserves.[19] It is thus likely that many smaller physician practices led by older physicians will continue to find it attractive to sell their practices to larger organizations that can offer their owners de facto return on their investment while also keeping the practices in operation and continuing to serve patients.

- The U.S. health care sector faces a necessary and inevitable period of transformation to respond and adapt to powerful forces of change. Population aging and rates of illness and disability will increase demands for care, even as health care workforce shortages require new care delivery strategies to meet the need. Greater investment in technologies, including artificial intelligence, are required to obtain efficiencies and increase affordability. Care will continue to move outside of institutional settings, probably driving an ongoing downsizing of the inpatient hospital sector. Increased expectations on health care to address health-related social needs will require webs of relationships among providers and the vast social services sector. Heightened security risks to health care information systems, including through cyberattacks, require replacement of legacy systems and investment in vastly greater cybersecurity. None of this will be accomplished through a 20th-century model of many relatively small and standalone physician practices and hospitals.

APG believes that public policy has a role in addressing some of the deleterious forces cited above that are driving consolidation, such as low Medicare payment for primary care physicians. As discussed further below, APG also believes that it will be in the public interest to track major ownership changes to better understand the degree of consolidation afoot. But aside from pursuing instances of clearly anti-competitive behavior, attempts by the agencies to thwart consolidation could be counterproductive, since much of the consolidation under way will better enable the sector to adapt to, and harness, the changes described above. In this respect, consolidation can also better prepare the sector to assume the accountability for costs, quality, and person-centered care that the Biden administration seeks.[20] APG further explains its reasoning in its recommendations below.

III. APG's Recommendations

As noted above, APG believes that there are legitimate areas of concern that the Department of Justice and FTC should monitor closely and act against as necessary, such as actions by specialty medical practices to engage in "roll-up" strategies that are overtly anti-competitive and price-increasing in their effects or intent. APG also believes that transparency about consolidation trends is important, and recognizes that many states have enacted legislation requiring pre-closing notification of material changes in ownership of health care entities.[21] A federal reporting requirement may also be appropriate to allow broader monitoring and understanding of consolidation, provided that the federal requirement would be limited to retrospective reporting of material changes in ownership that took place in the prior

[19] https://www.healthaffairs.org/doi/10.1377/hlthaff.17.4.53
[20] www.cms.gov/priorities/innovation/strategic-direction-whitepaper
[21] https://www.ropesgray.com/en/sites/healthcare-transactions-laws

year; assigned responsibility for reporting to the new owner; and set reasonable boundaries on the size of transactions that must be reported (e.g., more than $100 million in annual revenue).

APG urges the agencies in analyzing the effects of consolidation, and considering any future policy changes, to (1) consider first and foremost the appropriate policy goals of health care system transformation and the implications for both care delivery and payment, particularly in moving to more value-based health care; (2) develop a more nuanced understanding, and a better capacity to measure and evaluate the outcomes of, private investment and consolidation trends that drive toward this fundamental goal of health care transformation; and (3) develop a unified federal approach to this central aspect of national health care policy that will drive in a coherent and positive direction. Below, APG describes several areas where having the agencies adopt these approaches could pave the way for enlightened future policy actions.

Enabling the Transition to Value-Based Care

At least since the enactment of the Affordable Care Act, the nation has been on a journey in Medicare, Medicaid, the federal Health Insurance Marketplace, and commercial health insurance to create and test new models of delivering and paying for health care. The strongest results obtained to date – for example, in terms of net savings produced for Medicare through the Medicare Shared Savings Program (MSSP) – have been through ACOs led by independent physician groups and those with large portions of primary care providers.[22] Among the reasons are that savings can accrue from reducing avoidable and unnecessary hospital care, and that independent physician groups have clearer financial incentives relative to hospitals to reduce that care. Organizations with large numbers of primary care providers have also been able to create advanced primary care teams and practices that can better coordinate care for patients, particularly those with multiple chronic illnesses, and achieve similar objectives in terms of reduced hospitalization.

To undertake this degree of delivery system transformation, independent physician groups need substantial capital, both to make the investments in infrastructure needed to provide advanced primary care (chiefly in diverse personnel and health information technology) as well as to accept the downside risk inherent in capitation or two-sided risk arrangements. Some have worked with "enabler" organizations, including several backed by private equity, that partner with physician groups to help make these investments and assume some of the risk. Other, smaller physician practices see combining with others to form larger physician groups, or becoming part of a larger organization in general, as the only other avenue to being able to engage in delivery system transformation and alternative payment models. In other words, consolidation is a key means to obtaining these ends.

This reality suggests that the agencies should assume a wider lens in judging the effects of consolidation and private equity investment than the one that they currently employ. The agencies' request for information states that "Recent research suggests that transactions conducted by private equity funds have adversely affected patients including through worse patient outcomes and higher costs for care," but to our knowledge, there has not been an across-the-board examination in the research literature of the effects of different forms of consolidation and categories of private equity investment on these outcomes. We would also point out that the results obtained through MSSP and

[22] J. Michael McWilliams and others, "Savings or Selection? Initial Spending Reductions in the Medicare Shared Savings Program and Considerations for Reform," Milbank Quarterly (July 22, 2020)

the ACO REACH program, both in quality and cost savings, have been generally positive, and to the extent that these have occurred with the assistance of private equity and/or through consolidation, rebut the presumption that all effects on patients have been negative.

At any rate, the agencies should weigh multiple sources of information on these topics rather than relying on narrowly drawn studies. True "consumer welfare" in the modern health care era must comprehend a range of outcomes – price and affordability, to be sure, but also quality, access to the most effective interventions, and the overall cost effectiveness of care. Patient-reported outcomes and consumer preferences also matter, as does the ability of health systems to innovate in and adapt to the use of technologies such as artificial intelligence.

With respect to judging the competitive effects of mergers and consolidations, the agencies will also need alternative approaches that map more closely to delivery system transformation than more conventional measures, such as the degree of concentration within markets. Consider the fact that 90 percent of U.S. hospital markets are deemed to be concentrated under FTC and DoJ measures. Recent criticism of allegedly lax antitrust enforcement by the FTC of more than 1,000 hospital mergers from 2002 to 2020 suggests that 20 percent of these mergers "could have been predicted to meaningfully lessen competition," whereas enforcement actions were only brought against 1 percent.[23] The apparent conclusion is that a far wider swath of hospital mergers either did not lessen competition or would not have been predicted to lessen competition – making any assumed link between lack of competition and higher hospital prices more tenuous than is often implied. Survival is often the stronger motivator: As has been noted in the literature, "Many midsize community hospitals see merging with a competitor or joining a vertically integrated system led by a large tertiary care provider as two of the few viable alternatives to closing down."[24]

The primary reason that hospital prices have risen is not so much a lack of competition as it is that hospitals have operated under a business model that prioritizes hospital use for both inpatient and outpatient procedures, as well as unit-based reimbursement of higher-margin activities such as elective procedures. This model has been the de facto result of both public and commercial payment policies, a reality better understood as a market failure, and one that changes in public policy have only recently begun to address. A whole-of-government approach to the problem of lagged health care delivery and payment transformation should take precedence over other policy actions less relevant to the current health care marketplace and its problems, and the agencies as a group should develop the policies and tools to drive in this direction.

Evaluating Private Equity Investment in Primary Care

Specific sectors within U.S. health care suffer from woeful underinvestment, one of the most salient being primary care.[25] Longstanding underinvestment in primary care is leading to decreased provision of primary care across much of the nation. Public policy has periodically attempted, but largely failed to date, to address this chronic underinvestment. In 2019, 40 percent of adults in the

[23] https://www.aeaweb.org/articles?id=10.1257/aeri.20230340

[24] Glied S, Altman S, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0555?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed

[25] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983, p.3.

United States had no primary care visit in a year.[26] The investment in primary care as a share of total health care spending has dropped from 5.4% in 2012 to 4.7% in 2021; Medicaid and commercial insurer investment in primary care has decreased since 2012, and Medicare investment remains low, in large part because the MPFS undervalues primary care relative to specialty care.[27]

Even as the rate of total clinicians in primary care, inclusive of nurse practitioners (NPs) and physician assistants (PAs), has grown over the past several years, it is "still insufficient to meet the demands of overall population growth [and] a rapidly aging population with higher levels of chronic disease." [28] By 2026, 21 percent of family medicine, pediatric, and obstetrics and gynecology physicians (who also routinely provide primary care to women) —or about 32,000 doctors—will be 65 or older, and an estimated 23,000 physicians will leave the profession permanently.[29] Because medical students are overwhelmingly choosing careers as specialists, relatively fewer new primary care physicians will be available to replace retiring physicians. A recent JAMA study indicates that less than nine percent of third-year internal medicine residents are interested in careers in primary care.[30]

In recent years, private equity investors have stepped into this void of underinvestment in primary care. Many of these investors have seen important opportunities to help create new models of primary care that are team-based and person-centered; able to take on risk and participate in two-sided payment models and shared savings arrangements with the federal government; and not dependent solely on the relatively low levels of payment available through fee-for-service Medicare. Examples of these private-equity-backed primary care entities that have been members of APG are Iora Health, which was absorbed by One Medical, itself now a division of Amazon; Oak Street Health, now a division of CVS Health; VillageMD, a division of Walgreen; and WellBe Senior Medical. Several of these entities – Iora/One Medical, Oak Street, and VillageMD – have participated in the ACO REACH model (formerly the Global and Professional Direct Contracting model) sponsored by the Center for Medicare and Medicaid Innovation.

The fact that several of these organizations have been absorbed by public companies, rather than undergoing initial public offerings themselves, tells an important story. On the one hand, even under alternative payment models, it is extremely difficult to make much money in primary care, and certainly not to achieve the returns on investment sought by many private equity funds. This reality was underscored by the recent announcement by Walmart that it would shut down all its primary care clinics in stores, on the grounds that it did not see a path to profitability in the provision of primary care.[31]

On the other hand, the risks undertaken by the private equity investors to create these new primary care organizations and participate in alternative payment models drove them to the point of being attractive acquisition targets by other large public companies, which are now expanding them further to provide care for thousands more patients. Since purchasing Oak Street in 2023, for example, CVS Health opened 31 additional Oak Street locations, and as of year-end 2023, operated 204 centers across 25 states that provided care for approximately 270,000 patients. CVS says it "committed to expanding value-based care in the U.S. and delivering higher quality care to patients at a lower overall

[26] Relationships Matter: How Usual is Usual Source of (Primary) Care? Primary Care Collaborative. https://thepcc.org/resource/relationships-matter-how-usual-usual-source-primary-care-0
[27] https://www.milbank.org/wp-content/uploads/2024/02/Milbank-Scorecard-2024-ACCESS_v06.pdf
[28] Ibid
[29] www.mercer.com/content/dam/mercer/assets/content-images/north-america/united-states/us-healthcare-news/us-2021-healthcare-labor-market-whitepaper.pdf
[30] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2808652
[31] https://corporate.walmart.com/news/2024/04/30/walmart-health-is-closing

cost to the industry."[32] Time will, of course, tell whether the strategy pans out, but given the crisis in primary care, the agencies should not undertake any actions that impede attempts by the private sector to create new, sustainable models of primary care.

Accounting For Public Payment Realities in Health Care

The nation shouldn't be oblivious to the effect of health care consolidation on prices, and under the antitrust laws, pricing trends can be a legitimate signal that competition is absent or diminished.[33] But given the pressures on public payment in health care referenced earlier, other considerations should be given equal weight in any such analysis or forecast of the possible effects of ownership changes.

As noted above, the 2023 Medicare Trustees' report stated plainly that long-term forecasts of Medicare's financial viability are predicated on unrealistic expectations of productivity increases among health care providers, and therefore, how low payment can go while still inducing enough physicians and other providers to care for Medicare enrollees.[34] As actuaries at the Centers for Medicare & Medicaid Services put it: "There is a strong likelihood… that Congress would find it necessary to legislatively override or otherwise modify the [scheduled payment] reductions in the future to ensure that Medicare beneficiaries continue to have access to health care services."[35] The 2024 Medicare Trustees' report took the argument further: "If the health sector cannot transition to more efficient models of care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process used to date, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance."[36]

Amid this reality of suppressed Medicare payment – and the government forecast that it will lead to declining access and quality of care for Medicare beneficiaries – a concomitant rise in commercial prices in a given market may manifest the realities of maintaining a viable health care system in the face of low public payment. Such a situation may be inevitable in an era when millions more people are enrolled in Medicare and Medicaid, and public funding makes up an increasing share of health care revenues. In this respect, as referenced above, the agencies should develop a far more holistic set of measures – chiefly around quality and access to care – to evaluate the costs and benefits of consolidation, beyond just prices or size.

Diversification Versus Vertical Integration Within Health Care

The Request for Information notes that the agencies seek to learn more about such transactions as occur "when insurers purchase primary care practices outright." It further asserts that "concerns have

[32] CVS Health 2024 10k Filing, Securities and Exchange Commission, p. 11, at https://www.sec.gov/ix?doc=/Archives/edgar/data/64803/000006480324000007/cvs-20231231.htm

[33] https://www.justice.gov/atr/antitrust-laws-and-you

[34] The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Washington, DC, March 31, 2023.

[35] Shatto J, Klemens MK, Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers. Memorandum from CMS Office of the Actuary, March 31, 2023. Accessed at www.cms.gov/files/document/illustrative-alternative-scenario-2023.pdf

[36] The 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Washington, DC, May 6, 2024.

been raised that the acquiring payer may have the ability and incentive to weaken rival payers by charging higher prices for the rival's members to use the acquired practice, removing the acquired practice from rival payers' networks, or otherwise worsening contracting terms." APG wishes to comment on this concern from its perspective representing some formerly independent medical groups purchased by Optum, a division of the UnitedHealth Group, as well as other APG member organizations such as CenterWell Senior Primary Care, a care delivery organization developed by Humana in a strategic partnership with the private equity firm Welsh, Carson, Anderson & Stowe.

APG is aware of the Department of Justice's investigation of United Health Group[37] and will not comment on that ongoing investigation. At the same time, APG is also aware that both Optum/UHG and Humana would take issue with being characterized simply as "insurers" that purchased primary care practices, and APG agrees that the facts are on these organizations' side.

Although health insurance was at the root of both organizations' origins, much has changed in recent years, particularly in the wake of Affordable Care Act provisions that set minimum requirements for insurers' medical loss ratios. Whether or not these provisions succeeded in limiting premium increases is subject to debate,[38] but for health insurers, the law fueled their parent organizations' quest to diversify into other and potentially more lucrative types of health care services. Most organizations formerly thought of as "health insurers" now refer to themselves as "health solutions companies," or in UHG's case, as a "health care and well-being company," reflecting this massive diversification into other services – particularly involving data, information, and analytics to support the provision of health care, as well as direct care delivery through ownership of physician groups, home care entities, surgery centers, and more. Humana describes itself as "committed to putting health first – for our teammates, our customers, and our company" – through its two distinct units, Humana insurance services and CenterWell health care services.

At the same time, these organizations have committed to the provision of value-based health care and have demonstrated by their actions that they understand the importance of aligned incentives between payers and providers in creating new payment and delivery models. As a direct result of this commitment, Optum Health, the UHG division described in UHG's 10k filing as "an information and technology-enabled health services business," purchased formerly independent multispecialty medical groups such as California-based HealthCare Partners Inc. (now Optum California) that were early proponents of population-based payment and value-based care. Optum-owned medical groups care for patients insured by multiple health insurance carriers – well beyond UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, and UnitedHealthcare Community & State divisions – and are agnostic as to patients' sources of coverage.

Similarly, Humana in its 10k describes its CenterWell operations as "key to our integrated care delivery model," and its CenterWell Senior Primary Care operations as senior-focused, payor-agnostic, primary care centers" focused on care delivery strategies that "may lead to lower utilization associated with improved member health."

Although these organizational strategies are sometimes mischaracterized as being aspects of vertical integration, they are better understood as diversification within the broad health care sector. The financing of health care through health insurance is different from the delivery of health care, and

[37] https://www.wsj.com/health/healthcare/u-s-launches-antitrust-investigation-of-healthcare-giant-unitedhealth-ff5a00d2
[38] ttps://pubs.aeaweb.org/doi/pdfplus/10.1257/app.20180011

only rarely are the two capabilities combined in one organization, such as the Kaiser Foundation Health Plan and its allied Permanente Federation medical groups. In Kaiser's case, the insurance arm exists to finance care solely through the care delivery arm; in the case of Optum/UHG and Humana, the different arms of the organization are separate, and although the care delivery arms do provide care to some patients who are covered under the insurance arms, they also provide care to many patients covered by other insurers and are in fact agnostic as to the insurer/payer providing coverage.

APG recognizes that there is much confusion in the public mind about these aspects of the evolution in the delivery and financing of health care and is respectful of the DoJ investigation under way. However, much as Judge Carl J. Nichols of the United States District Court for the District of Columbia observed in allowing the acquisition of Change Healthcare by UnitedHealth Group to proceed,[39] any incentives for UHG to "misuse" the Optum groups to advance the interests of its insurance division are outweighed by the enormous risk to Optum's – and UHG's -- overall business that could result. APG would apply a similar observation to CenterWell and Humana.

Because these organizations, like APG, are focused on value-based health care, it is again appropriate for the agencies to develop a set of formal or informal metrics to evaluate their performance. On the insurance side, measures already exist – for example, through Medicare Advantage Star Ratings and HEDIS Measures – but gathering more information about how the care delivery side performs in terms of both costs and quality under aligned, shared-risk arrangements may help to build confidence that these aligned incentives between insurers and providers results in better patient care.

For example, APG member groups have participated for years in the Integrated Healthcare Association's California Healthcare Cost & Quality Atlas, which measures health care performance by geography for about 40 percent of Californians with commercial (14 million patients) and Medicare Advantage (2 million patients) insurance. This extensive measurement effort has proven that "When plans and providers share in the financial risk, better care and lower costs typically result," as the IHA reports.[40] IHA data reported to the California Department of Managed Health Care shows that for fully integrated, HMO-type providers and plans within the state, the annual rate of growth in health costs from 2017 to 2021 was 3.12 percent for HMOs, or less than one-third of the 9.93 percent annual growth rate for Preferred Provider Organization (PPO) or fee-for-service-based care.[41]

A similar effort at the national level to develop an "atlas" comparing similar organizational cost and quality outcomes would be a massive and costly undertaking, but at the same time, it would be advisable, as it would provide the agencies with the necessary broader context in which to view the organizational and ownership changes in health care. Without a comparable set of metrics, the agencies are left to focus on older paradigms that make increasingly less sense in a changing world.

[39] Memorandum Opinion, United States District Court for the District of Columbia, United States of America et al, Plaintiffs, vs. United Health Group Incorporated and Change Healthcare, Inc., Defendants. Civil Action No. 1:22-cv-0481 (CJN), September 21, 2022.

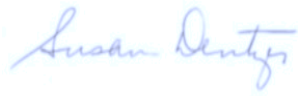
[40] Integrated Healthcare Association Atlas Fact Sheet at https://www.iha.org/wp-content/uploads/2024/04/IHA-Atlas-Fact-Sheet-24-MAR.pdf

[41] Rideout J, Integrated Healthcare Association, California Department of Managed Health Care FSSB presentation 02282024, at https://www.dmhc.ca.gov/Portals/0/Docs/DO/FSSBFeb2024/AgendaItem5_HealthCareandQualityAtlas.pdf

IV. Conclusion

APG appreciates the opportunity to provide its perspectives to the agencies on the important topics of health care consolidation. APG looks forward to working with you and your colleagues to address your concerns, as well as to illuminate actual trends within health care. Above all, APG's members share the agencies' goals of fostering affordable and accessible patient care, fueling greater accountability for costs and quality, and driving innovation across the health care system.

Sincerely,



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